FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0026914

Facility Name: CONCORD EXTENDED CARE

Address: 9401 SOUTH RIDGELAND (Number) OAK LAWN (City) 60453 (Zip Code)

County: COOK

Telephone Number: (708) 599-6700 **Fax #** (708) 599-6258

IDPA ID Number: 362833027001

Date of Initial License for Current Owners: 00/00/67

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name:: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) Edward Slack, CPA

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	134	Skilled (SNF)	134	48,910	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	134	TOTALS	134	48,910	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,536	352	3,915	6,803	8
9	SNF/PED					9
10	ICF	28,323	9,578	631	38,532	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,859	9,930	4,546	45,335	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.69%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1962

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 50 and days of care provided 3,775

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	195,865	26,264	12,307	234,436		234,436	(8,555)	225,881			1
2	Food Purchase		169,817		169,817	(21,480)	148,337	577	148,913			2
3	Housekeeping	219,101	27,263		246,364		246,364	(969)	245,395			3
4	Laundry	69,408	12,130		81,538		81,538		81,538			4
5	Heat and Other Utilities			98,007	98,007		98,007	1,173	99,180			5
6	Maintenance	68,331		63,976	132,307		132,307	3,662	135,969			6
7	Other (specify):*							1,606	1,606			7
8	**TOTAL General Services**	552,705	235,474	174,290	962,469	(21,480)	940,989	(2,507)	938,482			8
	B. Health Care and Programs											
9	Medical Director			3,484	3,484		3,484		3,484			9
10	Nursing and Medical Records	1,586,905	57,657	92,308	1,736,870		1,736,870	(17,756)	1,719,114			10
10a	Therapy	70,541	1,721	5,128	77,390		77,390		77,390			10a
11	Activities	84,937	6,758	4,539	96,234		96,234	14	96,248			11
12	Social Services	96,821		21,672	118,493		118,493	10	118,503			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							13,428	13,428			15
16	**TOTAL Health Care and Programs**	1,839,204	66,136	127,131	2,032,471		2,032,471	(4,304)	2,028,167			16
	C. General Administration											
17	Administrative			231,477	231,477		231,477	23,915	255,392			17
18	Directors Fees											18
19	Professional Services			234,129	234,129		234,129	(186,774)	47,355			19
20	Dues, Fees, Subscriptions & Promotions			46,732	46,732		46,732	(24,217)	22,515			20
21	Clerical & General Office Expenses	64,401	17,550	171,820	253,771		253,771	(51,856)	201,915			21
22	Employee Benefits & Payroll Taxes			402,931	402,931	21,480	424,411	(29,397)	395,014			22
23	Inservice Training & Education			912	912		912		912			23
24	Travel and Seminar			1,681	1,681		1,681	961	2,642			24
25	Other Admin. Staff Transportation			6,024	6,024		6,024	(5,484)	540			25
26	Insurance-Prop.Liab.Malpractice			144,930	144,930		144,930	825	145,755			26
27	Other (specify):*							26,177	26,177			27
28	**TOTAL General Administration**	64,401	17,550	1,240,636	1,322,587	21,480	1,344,067	(245,850)	1,098,217			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,456,310	319,160	1,542,057	4,317,527		4,317,527	(252,660)	4,064,867			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number CONCORD EXTENDED CARE #0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			77,446	77,446		77,446	74,156	151,602			30
31	Amortization of Pre-Op. & Org.			1,446	1,446		1,446	1,123	2,569			31
32	Interest			6,837	6,837		6,837	314,451	321,288			32
33	Real Estate Taxes			50,000	50,000		50,000	101,506	151,506			33
34	Rent-Facility & Grounds			498,060	498,060		498,060	(494,906)	3,154			34
35	Rent-Equipment & Vehicles			2,884	2,884		2,884	2,296	5,180			35
36	Other (specify):*											36
37	**TOTAL Ownership**			636,673	636,673		636,673	(1,374)	635,299			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		140,490	174,759	315,249		315,249	(3,362)	311,887			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			73,365	73,365		73,365		73,365			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		140,490	248,124	388,614		388,614	(3,362)	385,252			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,456,310	459,650	2,426,854	5,342,814		5,342,814	(257,396)	5,085,418			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	15,718	30		9
10	Interest and Other Investment Income	(12,406)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(367)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(118,000)	21		24
25	Fund Raising, Advertising and Promotional	(8,608)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,517)	20		28
29	Other-Attach Schedule	(57,782)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (183,962)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(73,434)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (73,434)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (257,396)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

CONCORD EXTENDED CARE

ID# 0026914

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc. Income	$ (17)	10	1
2	Collection Expense	(7,574)	21	2
3	Bank Charges	(4,426)	21	3
4	Theft Loss	(484)	21	4
5	COPE	(1,959)	20	5
6	Prior Year Legal Expense	(442)	19	6
7	Legal Fees (Bldg Co)	(1,340)	19	7
8	Bank Charges (Bldg Co)	(218)	21	8
9	VA Expense	(19,947)	10	9
10	Chamber of Commerce Dues	(295)	20	10
11	Mortgage Insurance	(21,080)	26	11
12				12
13				13
14				14
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99				99
100				100
101	Total	(57,782)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary					(1,278)	(1,461)	(5,816)					(8,555)	1
2	Food Purchase	(367)		(101)			1,045						577	2
3	Housekeeping							(969)					(969)	3
4	Laundry													4
5	Heat and Other Utilities			1,173									1,173	5
6	Maintenance			2,296		1,358	8						3,662	6
7	Other (specify):*				599	667	340						1,606	7
8	**TOTAL General Services**	(367)		3,368	599	747	(68)	(6,785)					(2,507)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(19,964)		(28)	(2,198)	8,414	5	(3,985)					(17,756)	10
10a	Therapy													10a
11	Activities			1	13								14	11
12	Social Services					10							10	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				12,269	1,159							13,428	15
16	**TOTAL Health Care and Programs**	(19,964)		(27)	10,084	9,583	5	(3,985)					(4,304)	16
	C. General Administration													
17	Administrative			276		23,506	133						23,915	17
18	Directors Fees													18
19	Professional Services	(1,782)	1,340	(186,599)			267						(186,774)	19
20	Fees, Subscriptions & Promotions	(13,379)	375	(11,228)			15						(24,217)	20
21	Clerical & General Office Expenses	(130,702)	218	11,320		67,116	192						(51,856)	21
22	Employee Benefits & Payroll Taxes				(29,397)								(29,397)	22
23	Inservice Training & Education													23
24	Travel and Seminar			675			286						961	24
25	Other Admin. Staff Transportation			(5,484)									(5,484)	25
26	Insurance-Prop.Liab.Malpractice	(21,080)	21,080	825									825	26
27	Other (specify):*				13,410	12,767							26,177	27
28	**TOTAL General Administration**	(166,943)	23,013	(190,215)	(15,987)	103,389	893						(245,850)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(187,274)	23,013	(186,874)	(5,304)	113,719	830	(10,770)					(252,660)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	15,718	50,348	8,090									74,156	30
31	Amortization of Pre-Op. & Org.		1,123										1,123	31
32	Interest	(12,406)	318,229	8,628									314,451	32
33	Real Estate Taxes		99,470	2,036									101,506	33
34	Rent-Facility & Grounds		(498,060)	3,146			8						(494,906)	34
35	Rent-Equipment & Vehicles			2,285			11						2,296	35
36	Other (specify):*													36
37	TOTAL Ownership	3,312	(28,890)	24,185			19						(1,374)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(3,362)						(3,362)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers						(3,362)						(3,362)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(183,962)	(5,877)	(162,689)	(5,304)	113,719	(2,513)	(10,770)					(257,396)	45

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
see attached		see attached		see attached		
				Concord Health Care Properties		Bldg Co

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	32	Interest Income	$	Concord Health Care Properties		$ (875)	$ (875)	1
2	V	32	Interest Expense				319,104	319,104	2
3	V	19	Legal Fees				1,340	1,340	3
4	V	21	Bank Charges				218	218	4
5	V	30	Depreciation				50,348	50,348	5
6	V	33	Real Estate Tax Expense				149,470	149,470	6
7	V	31	Amort - Closing Costs				1,123	1,123	7
8	V	26	MIP Expense				21,080	21,080	8
9	V	20	Licenses & Fees				375	375	9
10	V	33	Real Estate Tax Expense	50,000				(50,000)	10
11	V	34	Rent Expense	498,060				(498,060)	11
12	V								12
13	V								13
14	Total			$ 548,060			$ 542,183	$ * (5,877)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	05	Utilities	$	Care Centers, Inc.	100.00%	$ 1,173	$ 1,173	15
16	V	06	Maintenance		Care Centers, Inc.	100.00%	2,296	2,296	16
17	V	10	Nursing	34	Care Centers, Inc.	100.00%	6	(28)	17
18	V	11	Activities		Care Centers, Inc.	100.00%	1	1	18
19	V	19	Professional Fees	193,436	Care Centers, Inc.	100.00%	6,837	(186,599)	19
20	V	20	Dues and Subscriptions	12,136	Care Centers, Inc.	100.00%	908	(11,228)	20
21	V	21	Office & Clerical		Care Centers, Inc.	100.00%	11,320	11,320	21
22	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	675	675	22
23	V	26	Insurance		Care Centers, Inc.	100.00%	825	825	23
24	V	30	Depreciation		Care Centers, Inc.	100.00%	8,090	8,090	24
25	V	32	Interest		Care Centers, Inc.	100.00%	8,628	8,628	25
26	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	2,036	2,036	26
27	V	34	Rent - Building		Care Centers, Inc.	100.00%	3,146	3,146	27
28	V	35	Rent - Equipment & Auto		Care Centers, Inc.	100.00%	2,285	2,285	28
29	V	25	Bus Reimbursement	5,484	Care Centers, Inc.	100.00%		(5,484)	29
30	V	02	Food	101	Care Centers, Inc.	100.00%		(101)	30
31	V	17	Administration		Care Centers, Inc.	100.00%	276	276	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 211,191			$ 48,502	$ * (162,689)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	03	Housekeeping Salary	$	Care Centers, Inc.	100.00%	$	$	15
16	V	06	Maintenance Salary	4,457	Care Centers, Inc.	100.00%	4,457		16
17	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	599	599	17
18	V	10	Nursing Salary	69,072	Care Centers, Inc.	100.00%	66,874	(2,198)	18
19	V	10a	Rehab Salary		Care Centers, Inc.	100.00%			19
20	V	11	Activity Salary	2,475	Care Centers, Inc.	100.00%	2,488	13	20
21	V	12	Social Service Salary	21,672	Care Centers, Inc.	100.00%	21,672		21
22	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	12,269	12,269	22
23	V	17	Administration Salary	78,658	Care Centers, Inc.	100.00%	78,658		23
24	V	21	Office Salary	21,843	Care Centers, Inc.	100.00%	21,843		24
25	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	13,410	13,410	25
26	V	22	Employee Benefits	29,397	Care Centers, Inc.	100.00%		(29,397)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 227,574			$ 222,270	$ * (5,304)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary Salary	$ 4,854	Care Centers, Inc.	100.00%	$ 3,576	$ (1,278)	15
16	V	06	Maintenance Salary		Care Centers, Inc.	100.00%	1,358	1,358	16
17	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	667	667	17
18	V	10	Nursing Salary		Care Centers, Inc.	100.00%	8,414	8,414	18
19	V	12	Social Service Salary		Care Centers, Inc.	100.00%	10	10	19
20	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	1,159	1,159	20
21	V	17	Administration Salary		Care Centers, Inc.	100.00%	23,506	23,506	21
22	V	21	Office Salary		Care Centers, Inc.	100.00%	67,116	67,116	22
23	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	12,767	12,767	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 4,854			$ 118,573	$ * 113,719	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$ 5,042	Care Centers, Inc. - Health Systems Division	100.00%	$ 1,055	$ (3,987)	15
16	V	02	Food		Care Centers, Inc. - Health Systems Division	100.00%	1,045	1,045	16
17	V	06	Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	8	8	17
18	V	10	Nursing		Care Centers, Inc. - Health Systems Division	100.00%	5	5	18
19	V	17	Administration		Care Centers, Inc. - Health Systems Division	100.00%	133	133	19
20	V	19	Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	267	267	20
21	V	20	Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	15	15	21
22	V	21	Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	192	192	22
23	V	24	Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	286	286	23
24	V	34	Rent - Building		Care Centers, Inc. - Health Systems Division	100.00%	8	8	24
25	V	35	Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	11	11	25
26	V	39	Ancillary Enteral Supplies	7,630	Care Centers, Inc. - Health Systems Division	100.00%	4,268	(3,362)	26
27	V	01	Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	2,526	2,526	27
28	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	340	340	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 12,672			$ 10,159	$ * (2,513)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$ 42,931	XCEL Medical Supply, LLC	100.00%	$ 37,115	$ (5,816)	15
16	V	03	Housekeeping	7,155	XCEL Medical Supply, LLC	100.00%	6,186	(969)	16
17	V	10	Nursing	29,416	XCEL Medical Supply, LLC	100.00%	25,431	(3,985)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 79,502			$ 68,732	$ * (10,770)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 109,693	$ 109,693	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	109,693				(109,693)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 109,693			$ 109,693	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Noah Wolff	Owner	Administrative	16.67%	see attached	11	26.19%	Mgmt Fee	$ 76,410	17-3	1
2	Eric Rothner	Owner	Administrative	33.33%	see attached	1.35	1.88%	Mgmt Fee	76,410	17-3	2
3	Mark Steinberg	Relative	Administrative	0	see attached	1.38	2.76%	CCI alloc.	1,251	17-7	3
4	Melissa Rothner	Relative	Clerical	0	see attached			CCI alloc.	28	21-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 154,099		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	05	Utilities	Patient Days	1,640,756	39	$ 42,470	$	45,335	$ 1,173	1
2	06	Maintenance	Patient Days	1,640,756	39	83,080		45,335	2,296	2
3	10	Nursing	Patient Days	1,640,756	39	205		45,335	6	3
4	11	Activities	Patient Days	1,640,756	39	51		45,335	1	4
5	19	Professional Fees	Patient Days	1,640,756	39	247,437		45,335	6,837	5
6	20	Dues and Subscriptions	Patient Days	1,640,756	39	32,863		45,335	908	6
7	21	Office & Clerical	Patient Days	1,640,756	39	409,698		45,335	11,320	7
8	24	Travel and Seminar	Patient Days	1,640,756	39	53,743		45,335	675	8
9	26	Insurance	Patient Days	1,640,756	39	29,875		45,335	825	9
10	30	Depreciation	Patient Days	1,640,756	39	292,776		45,335	8,090	10
11	32	Interest	Patient Days	1,640,756	39	312,254		45,335	8,628	11
12	33	Real Estate Taxes	Patient Days	1,640,756	39	73,702		45,335	2,036	12
13	34	Rent - Building	Patient Days	1,640,756	39	113,857		45,335	3,146	13
14	35	Rent - Equipment & Auto	Patient Days	1,640,756	39	82,710		45,335	2,285	14
15	17	Administration	Patient Days	1,640,756	39	10,000		45,335	276	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,784,721	$		$ 48,502	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	03	Housekeeping Salary	Direct Cost			45,667	45,667			1
2	06	Maintenance Salary	Direct Cost			169,934	169,934		4,457	2
3	07	Emp. Ben. - Gen. Serv.	Direct Cost			29,646			599	3
4	10	Nursing Salary	Direct Cost			895,582	895,582		66,874	4
5	10a	Rehab Salary	Direct Cost			128,376	128,376			5
6	11	Activity Salary	Direct Cost			57,201	57,201		2,488	6
7	12	Social Service Salary	Direct Cost			219,790	219,790		21,672	7
8	15	Emp. Ben. - Healthcare	Direct Cost			180,204			12,269	8
9	17	Administration Salary	Direct Cost			1,334,207	1,334,207		78,658	9
10	21	Office Salary	Direct Cost			584,278	584,278		21,843	10
11	27	Emp. Ben. - Gen. Admin.	Direct Cost			267,060			13,410	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,911,943	$ 3,435,033		$ 222,270	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Patient Days	1,640,756	39	129,417	129,417	45,335	3,576	1
2	06	Maintenance Salary	Patient Days	1,640,756	39	49,148	49,148	45,335	1,358	2
3	07	Emp. Ben. - Gen. Serv.	Patient Days	1,640,756	39	24,132		45,335	667	3
4	10	Nursing Salary	Patient Days	1,640,756	39	304,530	304,530	45,335	8,414	4
5	12	Social Service Salary	Patient Days	1,640,756	39	354	354	45,335	10	5
6	15	Emp. Ben. - Healthcare	Patient Days	1,640,756	39	41,952		45,335	1,159	6
7	17	Administration Salary	Patient Days	1,640,756	39	850,731	850,731	45,335	23,506	7
8	21	Office Salary	Patient Days	1,640,756	39	2,429,052	2,429,052	45,335	67,116	8
9	27	Emp. Ben. - Gen. Admin.	Patient Days	1,640,756	39	462,069		45,335	12,767	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,291,386	$ 3,763,233		$ 118,573	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Billable Income	2,191,458		182,448		12,672	1,055	1
2	02	Food	Billable Income	2,191,458		834,365		12,672	1,045	2
3	06	Maintenance	Billable Income	2,191,458		1,400		12,672	8	3
4	10	Nursing	Billable Income	2,191,458		850		12,672	5	4
5	17	Administration	Billable Income	2,191,458		23,000		12,672	133	5
6	19	Professional Fees	Billable Income	2,191,458		46,205		12,672	267	6
7	20	Dues & Subscriptions	Billable Income	2,191,458		2,514		12,672	15	7
8	21	Office & Clerical	Billable Income	2,191,458		33,124		12,672	192	8
9	24	Travel & Seminar	Billable Income	2,191,458		49,456		12,672	286	9
10	34	Rent - Building	Billable Income	2,191,458		1,300		12,672	8	10
11	35	Rent - Equipment & Auto	Billable Income	2,191,458		1,830		12,672	11	11
12	39	Ancillary Enteral Supplies	Billable Income	2,191,458		84,436		12,672	4,268	12
13	01	Dietary - Salary	Billable Income	2,191,458		436,887	436,887	12,672	2,526	13
14	07	Emp. Ben. - Gen. Serv.	Billable Income	2,191,458		58,714		12,672	340	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,756,530	$ 436,887		$ 10,159	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Xcel Medical Supply, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, IL 60202
Phone Number: ((847) 328-7600
Fax Number: ((847) 328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Direct Allocation			$	$		$ 37,115	1
2	03	Housekeeping	Direct Allocation						6,186	2
3	10	Nursing	Direct Allocation						25,431	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 68,732	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 2201 W. MAIN ST.
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847) 905-4000
Fax Number: (847) 905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	C	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 109,693	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 109,693	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	HUD			Mortgage (new)			$	$ 4,162,518			$ 137,436	1
2	CIB Bank			Mortgage (old)							181,668	2
3												3
4												4
5												5
	Working Capital											
6	Diawa Loan	X		Working Capital		03/01/01			03/01/02		5,420	6
7	Insurance Financing										1,400	7
8	Money Market										17	8
9	TOTAL Facility Related						$	$ 4,162,518			$ 325,941	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										(4,653)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (4,653)	14
15	TOTALS (line 9+line14)						$	$ 4,162,518			$ 321,288	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 0 Line # n/a

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Interest Income						$	$			$ (12,406)	1
2	Interest Income (Bldg Co)										(875)	2
3	Care Centers allocation										8,628	3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (4,653)	21

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$	149,071	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	147,668	2
3. Under or (over) accrual (line 2 minus line 1).	$	(1,403)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	152,910	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	151,507	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997	125,056	8
1998	125,208	9
1999	133,766	10
2000	141,972	11
2001	145,632	12

2002 accrual = 2001 expense + 5% ($145,632 x 105% = $152,910)

Care Centers allocation $2036

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CONCORD EXTENDED CARE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0026914

CONTACT PERSON REGARDING THIS REPORT STEVEN LAVENDA

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	24-05-302-003-000	Long Term Care Property	$ 145,631.69	$ 145,631.69
2.	see attached	Home Office allocation	$ 70,261.69	$ 1,941.37
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 215,893.38	$ 147,573.06

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CONCORD EXTENDED CARE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0026914

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,133 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 88,713
2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: 2,569
4. Dates Incurred: _____

Nature of Costs: Finance Costs, Closing Costs
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	56,110	1962	$ 27,417	1
2	Care Centers allocation			11,622	2
3	TOTALS	56,110		$ 39,039	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1974	1,435		20	-		1,435	9
10	Various			1976	4,663		20	-		4,663	10
11	Various			1977	2,336		20	-		2,336	11
12	Various			1978	765		20	-		765	12
13	Various			1980	33,145		20	-		33,145	13
14	Various			1982	2,378		20	-		2,292	14
15	Various			1983	45,375		20	1,815	1,815	34,526	15
16	Various			1984	21,344		20	853	853	14,859	16
17	Various			1985	14,833		20	742	742	12,614	17
18	Various			1986	16,300		20	815	815	13,040	18
19	Various			1988	41,219		20	1,662	1,662	24,446	19
20	Various			1989	3,324		20	166	166	2,211	20
21	Various			1990	8,400		20	420	420	5,075	21
22	Various			1991	34,006		20	1,702	1,702	20,064	22
23	Various			1992	8,695		20	435	435	4,504	23
24	Various			1993	11,679		20	585	585	5,665	24
25	Various			1994	29,410		20	1,472	1,472	12,586	25
26	Various			1995	118,494		20	5,927	5,927	43,331	26
27	Various			1996	68,945		20	3,449	3,449	21,492	27
28	Various			1997	54,013		20	2,701	2,701	14,720	28
29	Various			1998	158,651		20	7,933	7,933	35,577	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		1,975,890	51,635		58,332	6,697	1,405,453	68
69	Financial Statement Depreciation			21,212			(21,212)		69
70	TOTAL (lines 4 thru 69)		$ 2,655,300	$ 72,847		$ 89,009	$ 16,162	$ 1,714,799	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,655,300	$ 72,847		$ 89,009	$ 16,162	$ 1,714,799	1
2	HOSES	1999	807		20	40	40	160	2
3	VALUES	1999	710		20	36	36	144	3
4	UTILITY ROOM WORK	1999	6,087		20	304	304	1,216	4
5	TILES FOR LOUNGE	1999	5,625		20	281	281	1,124	5
6	FOUNTAINS	1999	839		20	42	42	168	6
7	CW ENERGY SAVER	1999	590		20	30	30	120	7
8	PAINT	1999	822		20	41	41	164	8
9	DOOR KNOB	1999	547		20	27	27	104	9
10	LOCK & DOOR HANDLES	1999	1,840		20	92	92	345	10
11	FIRE ALARM REPAIR	1999	633		20	32	32	120	11
12	FIRE ALARM REPAIR	1999	1,443		20	72	72	270	12
13	FIRE ALARM REPAIR	1999	2,048		20	102	102	383	13
14	FLOWER PLATTING	1999	1,286		20	64	64	229	14
15	HINGES	1999	6,375		20	319	319	1,117	15
16	FABRIC	1999	722		20	36	36	120	16
17	DRAPES	1999	1,843		20	92	92	299	17
18	NURSE CALL	1999	830		20	42	42	209	18
19	ALARM DETERRANT	1999	607		20	30	30	141	19
20	TRANSMITTER	1999	712		20	36	36	167	20
21	FAUCET	1999	1,297		20	65	65	293	21
22	PLUMBING SUPPLIES	1999	753		20	38	38	170	22
23	VINYL LOUVER	1999	666		20	33	33	138	23
24	FANS	1999	684		20	34	34	142	24
25	FANS	1999	612		20	31	31	129	25
26	FANS	1999	1,074		20	54	54	216	26
27	CARPETING	1999	854		20	43	43	136	27
28	DRAPES	1999	585		20	29	29	92	28
29	NEW ROOF	2000	58,000		20	2,900	2,900	7,492	29
30	SINK PROJECT	2000	891		20	45	45	116	30
31	CONTROL HEAD	2000	523		20	26	26	63	31
32	TUCKPOINTING	2000	14,500		20	725	725	1,752	32
33	FUEL TANK	2000	1,133		20	57	57	133	33
34	TOTAL (lines 1 thru 33)		$ 2,771,238	$ 72,847		$ 94,807	$ 21,960	$ 1,732,271	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,771,238	$ 72,847		$ 94,807	$ 21,960	$ 1,732,271	1
2	PAINTING	2000	7,000		20	350	350	817	2
3	PAINTING	2000	3,350		20	168	168	392	3
4	CLOSET DOORS	2000	2,250		20	113	113	264	4
5	CLOSET DOORS	2000	1,500		20	75	75	175	5
6	CLOSET DOORS	2000	1,250		20	63	63	147	6
7	PAINTING	2000	9,000		20	450	450	1,013	7
8	CUBICLE CURTAINS	2000	2,688		20	134	134	268	8
9	DOOR FRAME	2000	1,200		20	60	60	120	9
10	CLOSETS/DOORS	2000	6,717		20	336	336	672	10
11	DOOR CLOSURE	2000	3,250		20	163	163	326	11
12	CLOSETS/DOORS	2000	560		20	28	28	56	12
13	COMPRESSOR	2000	2,437		20	122	122	244	13
14	SWITCH SYSTEM	2000	4,882		20	244	244	488	14
15	DOOR	2000	628		20	31	31	62	15
16	FIRE ALARM CABINE	2000	1,090		20	55	55	110	16
17	HOOD SYSTEM	2000	685		20	34	34	68	17
18	ADT SECURITY SERVICE	2001	4,051		20	203	203	355	18
19	VOICE MAIL SYSTEM	2001	997		20	50	50	83	19
20	FRIG AC	2001	660		20	33	33	55	20
21	LANDSCAPE	2001	959		20	48	48	76	21
22	FRIG A/C	2001	(565)		20	(575)	(575)	(591)	22
23	ELEVATOR REPAIRS	2001	717		20	36	36	51	23
24	PLUMBING	2001	500		20	25	25	35	24
25	FIRE PANEL	2001	5,600		20	280	280	397	25
26	PLUMBING	2001	500		20	25	25	31	26
27	PLUMBING	2001	500		20	25	25	29	27
28	PLUMBING	2001	1,916		20	49	49	96	28
29	AIR CONDITIONER	2001	585		20	15	15	29	29
30	PLUMBING	2001	632		20	16	16	31	30
31	PLUMBING	2002	500		20	50	50	50	31
32	PLUMBING	2002	500		20	50	50	50	32
33	ELEVATOR REPAIR	2002	875		20	80	80	80	33
34	TOTAL (lines 1 thru 33)		$ 2,838,652	$ 72,847		$ 97,643	$ 24,796	$ 1,738,350	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,838,652	$ 72,847		$ 97,643	$ 24,796	$ 1,738,350	1
2	BLINDS	2002	940		20	86	86	86	2
3	TYBONY	2002	2,141		20	178	178	178	3
4	PAINTING	2002	1,437		20	120	120	120	4
5	SEWER CLEAN OUTSIDE	2002	1,500		20	125	125	125	5
6	FIRE ALARM SYSTEM	2002	1,737		20	207	207	207	6
7	FIRE ALARM SYSTEM	2002	1,000		20	119	119	119	7
8	PLUMBING	2002	500		20	38	38	38	8
9	PLUMBING	2002	500		20	29	29	29	9
10	SMOKE ALARM	2002	502		20	42	42	42	10
11	WINDOW TREATMENTS	2002	2,448		20	122	122	122	11
12	PAINT	2002	743		20	74	74	74	12
13	WALK IN COOLER	2002	1,094		20	52	52	52	13
14	TELEPHONE SYSTEM	2002	501		20	13	13	13	14
15	HEAT EXCHANGER	2002	680		20	23	23	23	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,854,375	$ 72,847		$ 98,871	$ 26,024	$ 1,739,578	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,854,375	$ 72,847		$ 98,871	$ 26,024	$ 1,739,578	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,854,375	$ 72,847		$ 98,871	$ 26,024	$ 1,739,578	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 2,854,375	$ 72,847		$ 98,871	$ 26,024	$ 1,739,578	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,854,375	$ 72,847		$ 98,871	$ 26,024	$ 1,739,578	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 2,854,375	$ 72,847		$ 98,871	$ 26,024	$ 1,739,578	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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19									19
20									20
21									21
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,854,375	$ 72,847		$ 98,871	$ 26,024	$ 1,739,578	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 2,854,375	$ 72,847		$ 98,871	$ 26,024	$ 1,739,578	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,854,375	$ 72,847		$ 98,871	$ 26,024	$ 1,739,578	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 2,854,375	$ 72,847		$ 98,871	$ 26,024	$ 1,739,578	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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19									19
20									20
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,854,375	$ 72,847		$ 98,871	$ 26,024	$ 1,739,578	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 2,854,375	$ 72,847		$ 98,871	$ 26,024	$ 1,739,578	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,854,375	$ 72,847		$ 98,871	$ 26,024	$ 1,739,578	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 2,854,375	$ 72,847		$ 98,871	$ 26,024	$ 1,739,578	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,854,375	$ 72,847		$ 98,871	$ 26,024	$ 1,739,578	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Care Centers allocation			1996	$	$ 736	35	$ 820	$ 84	$	4
5				1962	339,532					339,532	5
6				1987	1,493,264	50,347	35	57,012	6,665	1,065,815	6
7				1962	112,250						7
8	Care Centers allocation			2002	16,015	30	35	44	14	44	8
	Improvement Type**										
9	Care Centers allocation			2002		273	20	18	(255)		9
10	Care Centers allocation			2001		1	20	4	3		10
11	Care Centers allocation			2000		1	20	2	1		11
12	Care Centers allocation			1999		13	20	26	(13)		12
13	Care Centers allocation			1998		5	20	11	6		13
14	Care Centers allocation			1997		53	20	106	53		14
15	Care Centers allocation			1996		137	20	210	73		15
16	Care Centers allocation			1997		1	20	17	16		16
17	Care Centers allocation			1994		7	20		(7)		17
18	Care Centers allocation			1993		3	20		(3)		18
19	Care Centers allocation			2002	14,829	28	20	62	34	62	19
20											20
21											21
22											22
23											23
24											24
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30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A-REP, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,975,890	$ 51,635		$ 58,332	$ 6,671	$ 1,405,453	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 375,616	$ 58,878	$ 35,773	$ (23,105)	10	$ 181,239	71
72	Current Year Purchases	35,491	1,027	14,244	13,217	10	14,244	72
73	Fully Depreciated Assets	364,615				10	364,615	73
74								74
75	TOTALS	$ 775,722	$ 59,905	$ 50,017	$ (9,888)		$ 560,098	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		CARE CENTERS ALLOCATION		$ 18,613	$ 3,131	$ 2,713	$ (418)	5	$ 10,179	76
77										77
78										78
79										79
80	TOTALS			$ 18,613	$ 3,131	$ 2,713	$ (418)		$ 10,179	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	3,687,749	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	135,883	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	151,601	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	15,718	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	2,309,855	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Care Centers allocation				3,146			5
6	Care Centers Health Systems allocation				9			6
7	TOTAL				$ 3,155 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 5,180 Description: see attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 68,751	$		$ 68,751	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			2,841			2,841	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			103,167			103,167	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				90,913		90,913	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						49,577		49,577	13
14	TOTAL			$		$ 174,759	$ 140,490		$ 315,249	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 6,666	$ 7,430	1
2	Cash-Patient Deposits	29,233	29,233	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	876,495	876,495	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	174,027	198,408	6
7	Other Prepaid Expenses	2,701	2,701	7
8	Accounts Receivable (owners or related parties)	45,424	45,424	8
9	Other(specify): See Supplemental Schedule	113,485	374,169	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,248,031	$ 1,533,860	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		27,417	13
14	Buildings, at Historical Cost		2,069,821	14
15	Leasehold Improvements, at Historical Cost	817,388	817,388	15
16	Equipment, at Historical Cost	823,090	823,090	16
17	Accumulated Depreciation (book methods)	(973,006)	(2,051,642)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule	4,284	81,748	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 671,756	$ 1,767,822	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,919,787	$ 3,301,682	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 636,316	$ 636,317	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,349	26,349	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	158,250	158,250	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,930	10,930	31
32	Accrued Real Estate Taxes(Sch.IX-B)		152,910	32
33	Accrued Interest Payable	11,560	34,038	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	3,600	3,600	35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	8,986	8,986	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 855,991	$ 1,031,380	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,162,518	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,162,518	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 855,991	$ 5,193,898	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,063,796	$ (1,892,216)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,919,787	$ 3,301,682	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,031,708	1	
2	Restatements (describe):		2	
3	Additional Paid in Capital	2,961,888	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,993,596	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	71,525	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(3,001,325)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (2,929,800)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,063,796	24	*

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,270,673	1
2	Discounts and Allowances for all Levels	(1,052,055)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,218,618	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	976,704	6
7	Oxygen	536	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 977,240	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	117,639	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,348	19
20	Radiology and X-Ray	3,360	20
21	Other Medical Services	68,031	21
22	Laundry	2,680	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 206,058	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12,406	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 12,406	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	17	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 17	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,414,339	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	962,469	31
32	Health Care	2,032,471	32
33	General Administration	1,322,587	33
	B. Capital Expense		
34	Ownership	636,673	34
	C. Ancillary Expense		
35	Special Cost Centers	315,249	35
36	Provider Participation Fee	73,365	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,342,814	40
41	**Income before Income Taxes (line 30 minus line 40)****	71,525	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 71,525	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing	1,976	2,555	59,286	23.20	2
3	Registered Nurses	6,808	7,884	178,548	22.65	3
4	Licensed Practical Nurses	23,532	26,380	510,800	19.36	4
5	Nurse Aides & Orderlies	75,035	86,414	815,280	9.43	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,422	6,322	70,541	11.16	8
9	Activity Director	1,024	1,128	11,821	10.48	9
10	Activity Assistants	8,558	9,268	73,116	7.89	10
11	Social Service Workers	6,453	7,873	96,821	12.30	11
12	Dietician					12
13	Food Service Supervisor	1,984	2,315	36,334	15.70	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,323	19,333	159,531	8.25	15
16	Dishwashers					16
17	Maintenance Workers	4,012	4,740	68,331	14.42	17
18	Housekeepers	23,742	26,053	219,101	8.41	18
19	Laundry	6,848	7,722	69,408	8.99	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,580	5,985	64,401	10.76	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,729	1,959	22,991	11.74	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	190,026	215,931	$ 2,456,310 *	$ 11.38	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	183	$ 7,453	01-03	35
36	Medical Director	monthly	3,484	09-03	36
37	Medical Records Consultant	monthly	4,472	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	1,575	10-03	39
40	Physical Therapy Consultant	68	1,728	10a-03	40
41	Occupational Therapy Consultant	75	3,400	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	43	2,064	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	UR Committee		378	10-3	47
48	CCI Allocation (see attached)		98,073		48
49	TOTAL (lines 35 - 48)	369	$ 122,627		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	25	$ 1,411	10-03	50
51	Licensed Practical Nurses	358	14,916	10-03	51
52	Nurse Aides	26	484	10-03	52
53	TOTAL (lines 50 - 52)	409	$ 16,811		53

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
Eric Rothner Management Fee	$ 76,410
Noah Wolff Management Fee	76,410
CCI Administrative Payroll	78,658
TOTAL (agree to Schedule V, line 17, col. 3)	$ 231,478
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 23,827
Crowe Chizek	Medicare Consulting	1,399
Maxxsource	Computer Package	1,200
IIT/Sourcetech	Computer Support	891
Personnel Planners	Unemployment Consult	2,095
LaSalle Appraisal Group, Inc.	Appraisal (re: loan)	3,000
Cindy Zola	IOC Consulting	833
TEG Services	Utility Mgmt Services	225
David Shires / National Hotline	PLOWS / Compliance	207
Various - see attached	Data Processing	4,118
Various - see attached	Legal	2,898
Care Centers, Inc.	various - see attached	193,436
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 234,129

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 89,081
Unemployment Compensation Insurance	18,639
FICA Taxes	185,044
Employee Health Insurance	68,401
Employee Meals	21,480
Illinois Municipal Retirement Fund (IMRF)*	
Misc. Employee Welfare	8,045
Pension Expense	3,587
Employee Physicals	736
TOTAL (agree to Schedule V, line 22, col.8)	$ 395,013

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	11,783
Health Care Worker Background Check	1,000
(Indicate # of checks performed 83)	
Dues & Subscriptions	5,699
Licenses	2,735
Advertising & Promotion	20,744
Yellow Page Advertising	2,517
Licenses & Fees (Bldg Co)	375
Care Centers allocation	923
Less: Public Relations Expense	( )
Non-allowable advertising	(20,744)
Yellow page advertising	(2,517)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,515

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,681
Care Centers allocation	675
Care Centers Health Systems allocation	286
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,642

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council of Long Term Care $6416**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,331** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **73,365**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **21,480** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees